Testimony of
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Good afternoon, Mr. Chairman and members of the committee. I am George Grob, Deputy Inspector General for Evaluation and Inspections within the Department of Health and Human Services. I am pleased to be here today to discuss the results of our study on Medicare beneficiary access to skilled nursing facilities (SNFs). Based on our interviews with hospital discharge planners and analysis of Health Care Financing Administration (HCFA) data, Medicare patients are not generally being denied access as a result of implementing the prospective payment system. To the extent that there are access problems, they appear to be localized.

INTRODUCTION

The Balanced Budget Act of 1997 changed Medicare skilled nursing facility to a prospective payment system in order to control Medicare program costs. Concerns have been raised by the health care industry, patient advocates, and Congress that the new payment system may adversely affect Medicare patients' ability to obtain needed care. The Balanced Budget Refinement Act of 1999 increased funding for skilled nursing facilities. Both the Administration and Congress are considering doing so again.

In the summer of 1999, we issued a report based on interviews with discharge planners. In *Early Effects of the Prospective Payment System on Access to Skilled Nursing Facilities, OEI-02-99-00400*, we reported that there were no serious problems with Medicare patients' access to SNF care, but that nursing homes were changing their admission practices. We recently repeated the inspection. It is based on interviews with a random sample of 202 discharge planners and an analysis of HCFA data related to the availability of nursing home beds, hospital lengths of stay, and the diagnoses of nursing home patients.

FINDINGS

Access to Care

We found that almost all discharge planners report that they are able to place Medicare beneficiaries in skilled nursing facilities (SNFs). In fact, about 80 percent of discharge planners state that they could place all of the Medicare patients. Another 14 percent estimate that between 1 and 5 percent of patients cannot be placed, while the remaining 5 percent put the estimate at over 5 percent. Most discharge planners indicate there are enough beds available in their particular area to accommodate Medicare patients. Many volunteer that they have flexibility because their own hospital beds are certified by the Medicare program to be used as SNF beds when needed. Discharge planners also indicate that patients whom they are unable to place remain in the hospital or eventually go home with or without home health care.

Further, Medicare data support the views of discharge planners that there are adequate skilled nursing home beds available for Medicare patients. From 1997 to 1999, the number of Medicare certified beds has increased by 23 percent. This increase is largely due to the increase in dual certified beds which are available for either a Medicare or Medicaid patient.

We also looked at pre- and post-PPS data for patients with diagnostic related groups (DRGs) from the first three months of years 1996 to 2000 to see if the proportion of patients with certain medical conditions is decreasing which would possibly indicate that certain patient types are experiencing a reduction in access to SNFs. We did not find any large decreases. Three DRGs had decreases over 1 percent: specific cerebrovascular disorder (-1.6 percent), respiratory infections and inflammations (-1.1 percent), and hip and femur procedures except major joint

(-1.0 percent). Four DRGs had decreases of less than 1 percentage point. Three DRGs showed an increase of less than 1 percent in the proportion of patients being discharged to SNFs. The largest increase was for simple pneumonia at 2 percent. (See Appendix B)

Some Delays

We found that some discharge planners experience delays in placing patients. For purposes of discharge planning, a delay occurs when a patient is medically cleared by a doctor for discharge, but no SNF bed has been secured. When specifically asked how often they experience delays in placing Medicare patients in SNFs, 43 percent rarely or never experience delays while 44 percent of discharge planners report that they sometimes experience delays. Twelve percent of discharge planners say they always or usually confront delays in placing patients. While 62 percent of discharge planners experience the same percentage of delays as prior to PPS implementation, 28 percent state that they have a higher percentage of delays since PPS implementation.

However, despite the reported delays, hospital lengths of stay are shorter. Medicare data from the first three months of 1996 through 2000 show a decrease in the average length of hospital stays for Medicare patients prior to a SNF admission. The average lengths of stay for the top 10 DRGs of patients discharged to SNFs show that the length of hospital stays decreased ranging from 1.8 days (specific cerebrovascular disorders) to 0 .2 days (septicemia). These data suggest that Medicare patients do not have extended lengths of stay while waiting for a bed in a nursing home.

On average discharge planners state that they have to contact about three nursing homes to place a Medicare patient in a SNF. Sixty-six percent of discharge planners had to contact approximately the same number of nursing homes prior to the implementation of PPS. Twenty-three percent respond that they had to contact fewer nursing homes since PPS implementation, and 9 percent respond that they contact more nursing homes.

Factors Affecting Placement Process

***Medical Needs*:** Eighty percent of hospital discharge planners who report delays in placing Medicare patients in SNFs state that patients with particular medical conditions or service needs are more likely to experience delays before being placed in skilled nursing facilities. Discharge

planners most often note that patients requiring intravenous or expensive drugs experience delays, with 44 percent reporting delays. They say that medically complex patients are also more likely to experience delays, with 34 percent reporting delays. These patients typically require extensive services by the nursing home staff to adequately care for their medical needs. Discharge planners point to similar medical conditions or service needs when asked which patients they are never able to place in nursing homes.

Prospective Payment System: Sixty-nine percent of discharge planners who mention delays in placement for medical conditions or service needs attribute these delays to PPS. The remaining

discharge planners note that they experienced delays for these particular medical conditions or services prior to the implementation of PPS.

About 63 percent of discharge planners volunteer that nursing homes have altered their admission process for Medicare patients since the implementation of PPS. For example, discharge planners report that nursing homes request additional patient information and on-site visits to evaluate the patient. A few discharge planners add that nursing homes analyze the reimbursement rates of the individual patients before they accept patients and that the routine screening and admission process takes longer. Most discharge planners respond that the reimbursement levels for these patients are too low to cover the expenses of the nursing homes.

On the other hand, about a third of discharge planners also state that patients requiring rehabilitation services (physical, speech, or occupational therapy) are experiencing fewer delays because of PPS. They indicate that higher reimbursement levels for these patients makes it advantageous for nursing homes to accept these patients. They also mention that rehabilitation patients are often short-term with foreseeable discharge dates and that their service needs are easily administered.

Other Factors: In addition to medical conditions and PPS, discharge planners note other reasons that Medicare beneficiaries experience delays before being placed in a SNF. The decision making process by patients and their family members is mentioned most often as a source of delays. The patient and the family may be considering placement options or waiting for a bed to become available in their nursing home of choice. Lack of nursing home beds in the area is also mentioned by the discharge planners. In addition, discharge planners also note that secondary payor issues cause delays. They explain that Medicare patients applying for Medicaid may experience delays waiting for approval.

Access for Dialysis Patients

In our previous report (*Effects of Prospective Payment System on Access to Skilled Nursing Facilities for Patients with End-Stage Renal Disease OEI-02-99-00402, 10/99*), we found that discharge planners most often listed end stage renal disease (ESRD) as the clinical condition that had become the hardest to place since the implementation of PPS. Discharge planners noted that the transportation to dialysis facilities for ESRD residents was not covered in the per diem rate. Although discharge planners continue to report delays for dialysis patients, we found in this report that dialysis patient delays dropped to the fifth most commonly cited delay. This is probably due to the fact that the Balanced Budget Refinement Act of 1999, which became effective April 1, 2000, extended pass-through payments to ambulance services to renal dialysis so that nursing homes no longer have to absorb these costs.

CONCLUSION

The findings in this follow-up study are consistent with those in the original report. While the study reveals some practice adjustments, there do not appear to be any major disruptions as a result of implementing the prospective payment system.

Mr. Chairman, I hope my comments this afternoon have been useful for you and the committee. I can assure you that the OIG will continue to monitor access to care and oversight of the quality of services for Medicare nursing home residents. I would be happy to answer any questions that you or the other committee members might have.